



Pauper's Affidavit



This form is used to reduce reinstatement payment fees by 50% for drivers who certify that they are unable to pay the entire amount due for reinstatement fees based on an evaluation of responses provided in the Household Information section of this form.

Ineligible suspensions are: Super Speeder, NonSufficient Funds and Safety Responsibility.

You must complete the entire form AND have it notarized!

***Minors with a suspension must have this form completed by a parent or legal guardian.**

Suspended Driver's Information

☐ I chose to opt-out of the Pauper's Affidavit.

Name: _____
Last Name, First Name MI
GA Driver License, Permit or Identification Card #: _____ Date of Birth: ____/____/____
MM/DD/YYYY

Household Information

****If you are seventeen (17) years of age or younger your parent or legal guardian will need to complete this section.**

I, _____, certify as follows:

Enter your Full Name Above

____ I am eighteen (18) years of age or older. **-OR-**

Initial

____ I am the parent or legal guardian of the suspended driver, who is under the age of eighteen (18) years.

Initial

1. That I, by reason of poverty, am unable to pay the entire fee required by O.C.G.A §40-5-9 to reinstatement my driving privilege.

2. That I live at _____
Street # Street Name Apt # City State Zip Code

3. ____ That my household consists of _____ people and my current gross annual household income is \$_____
in home Gross Income

-OR-

____ That I am in the custody of _____
Agency Name

Signature of Suspended Driver -OR- Suspended Driver's Parent or Legal Guardian - AND - Notary

This ____ day of _____ 20____
Day Month Year Signature of Suspended Driver -OR- Suspended Driver's Parent or Legal Guardian

Sworn to and subscribed before me, this ____ day of _____ 20____.
Day Month Year

Notary Signature Notary Seal

TO BE FILLED OUT BY DDS EMPLOYEE ONLY

Manager

Manager Approval? __Y __N

Approval Date: _____

Manager's Signature: _____

Print Manager's Name: _____

DDS Team Member Information

Team Member Signature: _____

CSC Location: _____ Date: _____

Total Payment Amount: \$ _____

WARNING: Any person knowingly making any false statement on this affidavit commits the offense of false swearing and shall be guilty of a felony.

MAIL IN ADDRESS: Department of Driver Services | Attn: RM-Reinstatement | P.O. Box 80447 | Conyers, GA 30013

To complete this form you must: fill in all information, sign, notarize and send with reinstatement payment fee(s).

If mailing this form to DDS it must be completed and notarized! We will return the form, reinstatement payment fee(s) and all other attachments if not completed

-OR- if you are not approved for this discount.